Name:							
This informat	tion is used to assist with safety planning.						
Monitoring/	Control						
Yes No	Does your partner try to control your daily activities?						
	Does your partner go through your personal belongings?						
	Is your partner controlling or violent outside the home?						
	Does your partner listen in or to your phone calls or tapped the phones?						
	Does your partner read and/or track your mail?						
	Does your partner monitor your email or internet use?						
	Does your partner ask you to check in constantly regarding your activities/whereabouts?						
	Does your partner ask your children to report on your activities and/or whereabouts?						
	Has your partner ever appeared unexpectedly someplace where you were?						
	Does your partner watching/follow/stalk you?						
	Does your partner have another person watching you? Friend Family Member Paid stranger or Professional Detective						
Threats/Con	ntrol						
Yes No	Has the abuse been escalating/getting worse?						
	Does your partner try to intimidate you?						
	Does your partner tell/threaten you that he/she will never let you go?						
	Does your partner have access to a weapon? List the weapons you think your partner has or has access to:						
	Do you have access to a gun/weapon?						
	Has your partner threatened you with a weapon?						
	Has your partner ever threatened to take the children?						
	Has your partner ever taken your children without your permission?						
	Has your partner prevented you from taking the children with you when you have attempted to flee?						
	Has your partner threatened to kill/harm you?						
	Has your partner ever driven recklessly or caused an accident with you in the car?						
	Has your partner ever threatened or harmed a pet?						
	Do you believe your partner is capable of killing you?						
	Do you feel this won't end until one of you is dead?						

	e drugs and/or alcohol does your p	artner use?					
Yes No	Is your partner taking medications? If so, what kind?						
	Has your partner been violent while using alcohol and/or drugs?						
	Has your partner forced you to use drugs/or alcohol?						
	What type of alcohol and/or drugs do you currently use?						
	Are you currently using any prescriptions? If yes, what kind?						
	Has your use changed recently? If yes, how so?						
	While under the influence have you found yourself in jeopardy? Was it recently? Yes No Have you ever felt that you needed to use prescriptions, alcohol, or drugs to cope?						
Have you ever received treatment for drug/alcohol problems?							
Partner's History							
Yes No Has your partner ever been convicted of a crime?							
	If so, what crime:	yes, Misdemeanor	or	Felony	·		
Does your partner have any mental health issues and/or is he/she receiving treatment?							
Has your partner ever attended domestic violence treatment? If yes, circle one: Currently involved with a program Attended in the past Which program?							
	Does your partner know you are If yes, please check the service Crisis Line Counseling Order of Protection						
Please fill out t	his section in case of an emerger	ncy.					
Partner's Name:		Nickname/Alias:					
Gender:	Male Female						
Asian	can Indian/Alaskan Native	Arab/Middle Eastern Black/African America Mixed Race:		Caucasian Hispanic/Latino			
Date of Birth: _	//	Height:		Weight:			
Eye Color:		Glasses? Yes	No	Hair Color:			
Current Addres	ss of partner:						
Name/Address	of Employer:			City Work Hours:	Zip Code		
Vehicle Yr./Ma	City ke/Model:	Zip Coc					
Vehicle Color:		Vehicle License:					
Places your pa	ortner frequents:						